1.2 Organization and Staffing

ATTACHMENT 1.2-C

The following are descriptions of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities:

1) **Medical Director**

The medical director is responsible for establishing policy and standards which govern coverage and reimbursement for Medicaid services covered under the plan; establishing eligibility criteria for participation of providers; participating in the development of new programs to meet changing Medicaid regulations; directing professional consultants in daily operations and program planning.

The medical director serves as staff support for the Drug Use Review Board which is responsible for implementation of a drug use review program for covered outpatient drugs.

2) **Pharmacy Services**

Registered Pharmacist

The pharmacist is responsible for daily management of the pharmacy program which includes responding to inquiries regarding program coverage; preparing drug pricing file maintenance changes; arranging with the providers for special pharmacy services for a recipient; working with MMIS contract staff on changes required for pharmacy claims processing; developing policy and coverage changes to meet Federal or State requirements; maintaining the Pharmacy Provider Manual; auditing prescription drug claims covering special circumstances; and adjudicating pended pharmacy claims.

The pharmacist serves as staff support and coordinator for the Drug Use Review Board.

3) **Utilization and Management Unit**

Unit Director and Secretary

a. The following utilization review activities are performed by the West Virginia Medical Institute (PRO) under contract:

* Inpatient hospital services - retrospective review of necessity for admission, length of stay, and appropriateness of services on a sample basis; preadmission review for organ transplant services.

* Nursing facility services - preadmission review of the medical necessity for admission to the facility; PASARR Level I review and referral to Level II where appropriate.

b. The following utilization control activities are carried out by state utilization review staff:

* S/URS post payment review of provider and recipient exceptions.

* Imposing provider and recipient limitation/restriction edits.

* Liaison with Medicaid Fraud Section, Inspector General Division.

Professional Staff:

-Nurse II - Recipient/Provider UR Specialist - one
-Pharmacy Consultant - Reconciliation of Drug Rebate disputed claims - one

Support Staff:

-Manager - Cost Settlement and Accounts Receivable - one
-S/UR Policy Specialist - two
-Coordinator, Claims History - one
-UR Documentation Specialist - one

c. Management activities include:

* Preparation of contracts for professional medical consultants to the Medical Assistance Unit.

* Staffing the Facility and Ambulance Boards

* Preparation of Medicaid Provider regulations for transportation, hospitals, rural health clinics and ambulatory surgical center services.

d. Physician Assured Access System (PAAS)

The PAAS program is designed to provide health care for Medicaid recipients who are part of a family with children. The family selects a physician or clinic to manage their medical care from the PAAS providers in their geographic area. The name and telephone number of the PAAS physician is printed on the medical identification card.

The PAAS physician arranges for specialist care when needed for a patient. Some services such as vision, hearing, dental, podiatric and mental health services, do not require a referral from the PAAS physician.

Professional staff: 1 Registered Nurse III

Support staff: 1 Director
1 HHR Specialist
2 Office Assistants
4 Clerks

4) **Long Term Care and Alternate Care Unit**

Nursing Facility Services; ICF/MR Services; Aged/Disabled and Mentally Retarded/Developmentally Disabled Section 1915(c) Waiver programs; Prior Authorization and Utilization Review for Psychiatric and Psychological Services; Inpatient Psychiatric Hospitals (age 21 and under); Home Health Services; Hospice Care; and Home Care for Disabled Children (TEFRA).

The Long Term and Alternate Care Unit is responsible for:

- The issuance of provider agreements with nursing facilities, ICF/MR and inpatient psychiatric hospitals for children age 21 and under.

- The issuance of cost reporting financial and statistical documents, and reimbursement rates for nursing facilities, ICF/MR and psychiatric hospitals.

- The certification and annual recertification for ICF/MR, MR/DD Waiver, and Home Care for Children (TEFRA) clients.

- The approval of admissions to inpatient psychiatric hospitals for children age 21 and under.

- The annual inspection of care of and onsite reviews for ICF/MR clients.

- The annual onsite utilization review of all psychiatric inpatient hospitals and patients.

- The development of policies and maintenance of provider regulations, training of providers and technical assistance.

- The arrangement and participation in provider appeals of reimbursement rates, disallowances or other agency actions.

- The coordination of fair hearings for clients whose services are reduced, delayed, denied or terminated.

- The maintaining of liaison with facility regulatory agencies, provider associations, consumer representatives, and other interested parties affected by policy development, implementation, revision and coverage.

- The oversight of policy development and program operations for both the Aged/Disabled and MR/DD Waivers, and the preparation and submittal of the HCFA-372 Annual Reports on these program.

- The development of policies, oversight of implementation and monitoring of Hospice and Home Health Care Services.

Professional Staff:

Licensed M.D. Psychiatrist - one
Licensed M.A. Psychologists - two
M.S. Registered Nurse - one
B.A. Registered Nurse - one
Registered Nurse - one
M.A. Program Manager (QMRP) - one
M.S. Habilitation Specialist (QMRP) - one
B.A. Habilitation Specialist (QMRP) - one

Support Staff:

Office Assistant - one
Secretary - one

5) **Community Behavioral Health Unit**

I. Program Development:

- Definition and parameters of clinical services to be provided under Medicaid to target population, procedure codes, criteria, staff qualifications, services limitations, rates, documentation requirements, etc., for Behavioral Health Services provided through OBHS, Social Services, and The Commission on Aging - Community Care Program.

- Certification of Providers: Development and application of protocol for certification of providers of specific Medicaid reimbursable services, under four state plans: Case Management, Clinic Services, Personal Care and Rehabilitation Services.

- Work with Office of Health Facilities and Licensure on applications of new providers, certification process and Certificate of Need (HCCRA) process.

- Enforce certification process of new providers.

- On-site review for approval of all Day Treatment, Crisis Support, Crisis Stabilization and Partial Hospitalization Programs.

- Linkage activities with OBHS, Social Services, Commission on Aging, Office of Health Facilities and Licensure, IS&C, Waiver Programs, IPPC, Deputy Commissioners, to keep program staff advised of status of Medicaid services and to assist in identification and resolution of problems related to these services.

- Contact with other states to update information about similar programs, Federal Regulations, or new initiatives.

II. Training and Technical Assistance:

Activities include training providers on use of policy manuals and implementation of changes in policy; providing technical assistance on implementation and documentation of services, and providing interpretation of provider manuals.

III. Provider Services:

- Responding to inquiries related to status of claims, claims payments, client eligibility, and program issues.

- Preparing correspondence related to client complaints, investigations, manuals, policies, contracts and Letters of Agreement.

- Conducting meetings with provider representatives regarding the correct implementation and documentation of services.

IV. Quality Assurance/Utilization Review:

- Home Visits: On-site observation to examine client progress, levels of care and assess providers' caretaking. Recommendations for referral and follow-up are included in the report.

- On-Site Monitoring Reviews: These reviews are coordinated with Office of Health Facilities, Licensure and Certification and may require 1-5 days per visit depending on the site and number of programs or services to be reviewed.

- Prior Authorization: Review and approve or deny services the following services:

  Supportive Individual Counseling and Supportive Group Counseling; Personal Care - Medley at Risk; Personal Care - Community Care; Personal Care - Behavioral Health.

- Desk Audits: Monthly Management Information reports generated from the MMIS by provider and service codes are reviewed by agency staff. Based on this review, staff may contact the provider for clarification or additional information, or may schedule an on-site review.

- Provider Utilization Review Process: Providers are required to develop the following policy and procedures for a utilization review process as it relates to the provision of Medicaid services.

  1. The composition of the internal Utilization Review Committee.

  2. The process for selecting the required 10% record review of Medicaid-billed services which includes clinic services, case management and personal care.

  3. The process for reviewing services billed, including:

     * verification that services billed are documented in the progress notes or other appropriate section of the clinical record;

     * verification that units of service billed are documented in the clinical record;

     * verification that clinic and personal care services billed are authorized by the Interdisciplinary Treatment Team (i.e., documented in the treatment plan with physician signature); and

     * verification that clinic services were provided in a licensed site where required by regulations.

  4. The timeframe for submitting summary Utilization Review reports to the Office of Medical Services will be February and August of each year: The February report covers period of July through December. The August report covers period of January through June.

5. The process for initiating and following up on corrective actions for billings found out of compliance to include reconciliation of billings with documentation, use of void adjustment forms and sanctions.

Professional Staff:
Unit Director, QMRP - one
Assistant Director, QMRP - one
Registered Nurse IV - one
Registered Nurse III - two
Psychologist - Ph.D. - one

Support Staff:
Secretary - one
Monitoring Assistant - one

6) **Technical Assistance and Customer Services**

Director
Assistant Director
Secretary
Office Assistant

* Developing and maintaining regulations for coverage of physicians', dentists', and optometrists' services; laboratory and radiological services; durable medical equipment and supplies; physical therapy, occupational and speech therapy services.

* Establishing criteria for provider eligibility to participate in the program.

* Directing provider/client communication services.

* Coordinating Procedure Code file maintenance.

* Staff to Dental Enhancement Board.

* Liaison with the Department of Health, EPSDT, Early Intervention and Right From The Start programs.

* Liaison with Department of Education serving Medicaid children in the school health programs.

a. Vision and Dental Services

Staff responds to provider and public requests for information regarding coverage or payment; prepares prior authorization requests for the consultants; resolves pended claims; reviews correspondence and refers to consultants or unit director for response as appropriate.

Professional Staff:
General Dentist Consultant
Orthodontist Consultant
Ophthalmologist Consultant
Optometrist Consultant

Support Staff:
Two

b. Case Planning/Prior Authorized Services

Physician order/prescription is required.

* In-Home Care

Staff coordinates with the provider and case manager/social worker to plan appropriate care for home bound Medicaid patients. Services include durable medical equipment; home IV therapy; oxygen, and private duty nursing services.

* Prior Authorized Services

Staff reviews requests for services requiring prior approval which include certain surgical procedures, speech, occupational and physical therapy procedures, orthotics and prosthetics, air ambulance transport, renal drugs, durable medical equipment and medical supplies.

* Out of State Services

  Covered services prescribed for a Medicaid recipient that are not available in state or in adjacent states, are arranged with the out-of-state provider for the recipient, including transportation, e.g., organ transplantation.

* • Staff reviews and calculates payment for claims that require manual pricing, e.g., medical supplies, and resolves other pended claims for these services.

Professional Staff:
Registered Nurse IV - one
Support Staff - five

c. Sterilization/Hysterectomy Services

Prepayment review of claims to assure that the requirements for informed consent are met.

Support Staff: two

d. Provider Enrollment Services

Applications for enrollment as a provider in the program are reviewed using established criteria for the provider type, or specialty within the provider type prior to enrollment. Applications in question are referred to the Medical Director for review. Payment rates for providers with individual rates for services are maintained on the provider file, e.g., inpatient hospital per diem rates.

Providers approved for participation in the program are assigned a provider number and furnished the appropriate provider regulations and billing instructions.

Toll-free telephone lines are available for provider inquiries regarding the Medicaid program. Response to written correspondence from providers is also a function of provider services staff.

Professional staff:
Medical Consultants

Support staff:
Supervisor - one
Office Assistants - eight

7) **Policy and Regulation Unit**

Unit Director and Secretary

The policy and regulation unit is responsible for:

* Preparation of state plan amendments to meet federal regulations; to implement coverage of optional services; to change coverage of medical services and reimbursement methodology; or to implement changes in categories of recipients eligible for Medicaid.

* Preparation of regulations governing the participation of providers in the Medicaid program.

* Administration of the special pharmacy program for H.I.V. patients under contract with the Department of Health.